DSS-AA-659 10/04

PHYSICIAN'S REPORT/ORDER

For Office Use Only
Requested by/for:

☐ EA ☐ ASA ☐ DRS

(applicant's name) (DOB)

(address)

(medicaid number) (Social Security Number)

Date of last physical exam _____ Physician's name _____

CURRENT DIAGNOSIS AND ICD-9 CODE	MEDICATIONS

CHECK ALL THAT APPLY TO THE APPLICANT'S CURRENT CONDITION:

☐ Capable of self-preservation in emergencies
☐ Supplemental oxygen
☐ Terminal illness
☐ Therapeutic diet
☐ Non-ambulatory
☐ Requires supervision to self administer medications
☐ Non-compliant with medication regimen
☐ Requires a medication dispensing device of any type
☐ Incontinent/Bowel/Bladder Program

☐ Requires limited hands on physical assistance with activities of daily living (toileting, transferring, mobility, eating, personal hygiene and bathing)

PHYSICIAN'S ORDER for SERVICES

☐ Would benefit from rehabilitation services

☐ Would benefit from nursing facility care services

☐ Has a medically necessary need for services provided through Personal Care or HCBS IN-Home or Assisted Living Waiver services.

☐ Has a medically necessary need for services provided through personal care but is capable of participating in competitive employment of at least 40 hours per month. DSS/Adult Services & Aging will review continuing need for in-home services while the Dept. of Human Services will monitor the needs of those at the worksite. Staff will communicate with the Physician as needed.

_____ **MD/DO** _____

Signature of Physician (Date)

MAKE ADDITIONAL COMMENTS REGARDING THE APPLICANT ON REVERSE SIDE

A recent History and Physical or Discharge Summary may be provided in addition to the above information